The Remittance Advice

Understanding Claim(s) Status

This chapter shows how to:

- Obtain the Agency Remittance Advice (RA).
- Determine what claims were paid.
- Determine if any claims were denied.
- Review adjustment reason and remark codes (Explanation of Benefit codes) to research denied claims.
- Understand the payment and RA cycle.
- Review claims in process.

The RA provides providers with the information needed to check the status of the claims. Providers can apply payments to the client accounts from the "Claim Paid" section(s).

Why Is Reconciling the Remittance Advice (RA) Important?

The Health Care Authority (the Agency) makes payments to providers weekly. The Agency always pays on Monday each week and claim submission cutoff in the payment system is Tuesday at 6 p.m.* to make payment the following Monday for a "clean" claim. Clean claims are claims that have all of the required data elements and do not conflict with Agency program policies. Clean claims submitted after cutoff will be paid the following payment cycle of the following Monday. The Agency sends out the RA weekly through a variety of methods and it is always following Monday's payment cycle.

> ***Note:** Claims may arrive in the payment system before 6 p.m. on Tuesday, but not be processed until after the cut off time. These claims will miss the next Monday payment and be paid the following payment cycle of the following Monday.

The RA is broken down into key elements:

- RA Newsletter
- RA Summary
- Paid Claims
- Denied Claims
- Claims – In – Process
- Adjustment Claims

Each key section may be split into multiple parts that could include "paid claims -physician claims" and "paid claims - Medicare crossover claims" located on different pages. Be sure to look for possible multiple sections when reconciling the RA.

Disclaimer

A contract, known as the Core Provider Agreement, governs the relationship between the Agency and providers. The Core Provider Agreement's terms and conditions incorporate federal laws, rules and regulations, state law, the Agency rules and regulations, and the Agency program policies, numbered memoranda, and billing instructions, including this Guide. Providers must submit a claim in accordance with the Agency rules, policies, numbered memoranda, and billing instructions in effect at the time they provided the service.

The Key Steps

1. Retrieve Remittance Advice

2. Review Updates and Key Messages

3. Review Summary

4. Review Paid Claims

5. Review and Research Denied Claims

6. Review Adjusted Claims

7. Review In Process Claims

8. Review the EOB Codes

Key Step

1

1. Retrieve Remittance Advice

Why?

There are several ways to obtain the Remittance Advice (RA). Providers will want to select the method that bests suits their business needs.

How

- The methods are:
  - PDF file
  - Electronic 835

- Retrieve the RA via the ProviderOne Portal
  - Log in to ProviderOne
  - Choose the **EXT Provider Claims/Payment Status Checker** or **EXT Provider Super User** profile
  - Select "View Payment" (RHCs and FQHCs select "View Capitation Payment" to view enhancement/Managed Care RAs)
  - The segment below will be displayed.
  - Click on the **RA/ETRR Number** in the first column to review a PDF of the RA. ProviderOne will hold 4 years of RAs generated in ProviderOne.

Close

RA/ETRR Payment List:

Filter By : Billing Provider NPI **And** Go

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
0000001	0000001	04/11/2013	04/12/2013	1726	$ 93.13	$ 59.90	$ 47.01	
0000002	0000002	04/04/2013	04/05/2013	1787	$ 93.13	$ 59.90	$ 47.01	

Pitfalls

- **Failing to use the correct user profile. This may result in not being able to retrieve the RA in ProviderOne.**

Key Step
2

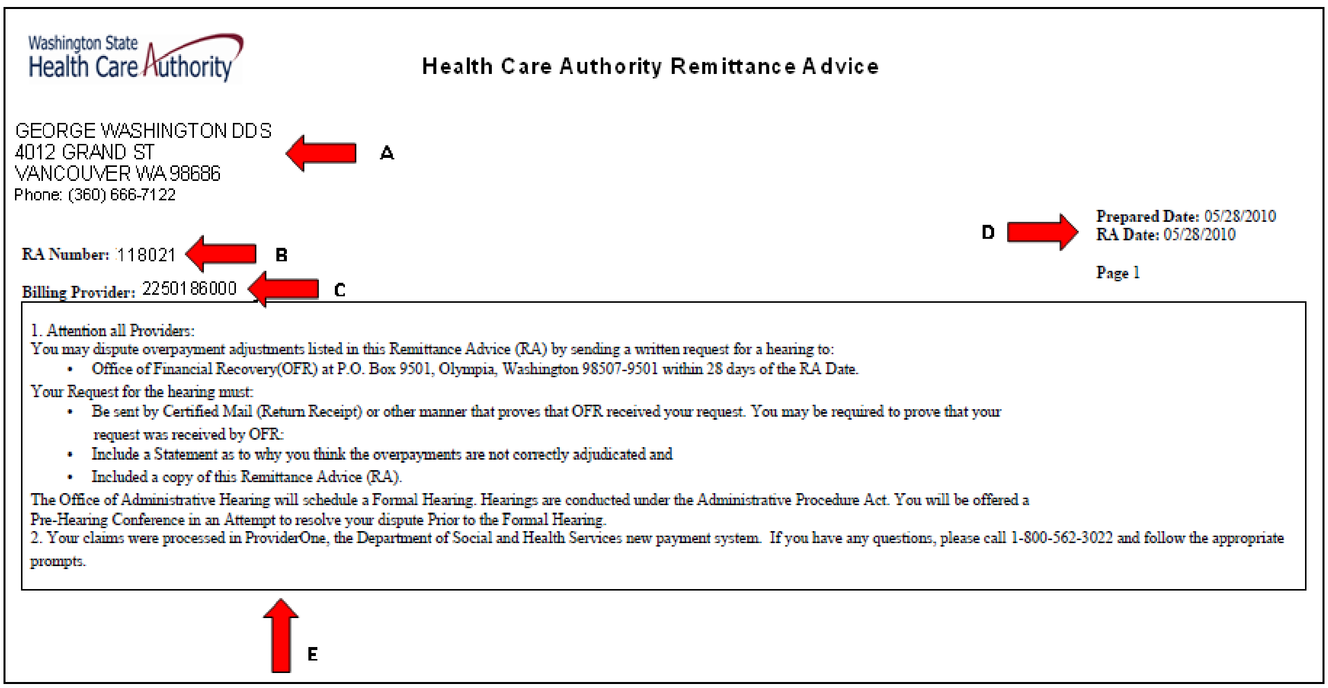
2. Review Updates and Key Messages

Why

The Agency uses the RA "newsletter" to communicate changes and new information. Taking the time to review this section will ensure current important Medical Assistance changes and messages will be seen.

How

View the first page of the RA.


Washington State Health Care Authority

Health Care Authority Remittance Advice

GEORGE WASHINGTON DDS
4012 GRAND ST
VANCOUVER WA 98686
Phone: (360) 666-7122

A

Prepared Date: 05/28/2010
RA Date: 05/28/2010

D

Page 1

RA Number: 118021 B

Billing Provider: 2250186000 C

1. Attention all Providers:
You may dispute overpayment adjustments listed in this Remittance Advice (RA) by sending a written request for a hearing to:
- Office of Financial Recovery(OFR) at P.O. Box 9501, Olympia, Washington 98507-9501 within 28 days of the RA Date.

Your Request for the hearing must:
- Be sent by Certified Mail (Return Receipt) or other manner that proves that OFR received your request. You may be required to prove that your request was received by OFR:
- Include a Statement as to why you think the overpayments are not correctly adjudicated and
- Included a copy of this Remittance Advice (RA).

The Office of Administrative Hearing will schedule a Formal Hearing. Hearings are conducted under the Administrative Procedure Act. You will be offered a Pre-Hearing Conference in an Attempt to resolve your dispute Prior to the Formal Hearing.
2. Your claims were processed in ProviderOne, the Department of Social and Health Services new payment system. If you have any questions, please call 1-800-562-3022 and follow the appropriate prompts.

E

Note: This example of the RA is just an approximation of a providers actual RA.

A. Provider demographic information.
B. The number assigned to the RA.
C. The NPI provider number used in billing the Agency.
D. The payment date and the date this RA was prepared.
E. The main body of this RA page is our newsletter with important provider update information (sometimes specific to certain provider groups).

NOTE: Providers can call the IVR to check their warrant (check) amount. See Appendix O.

Pitfalls

- **Failing to review this section of the RA. The Agency uses the RA to communicate important changes. Providers may miss an update that could affect their payment.**

Key Step
3

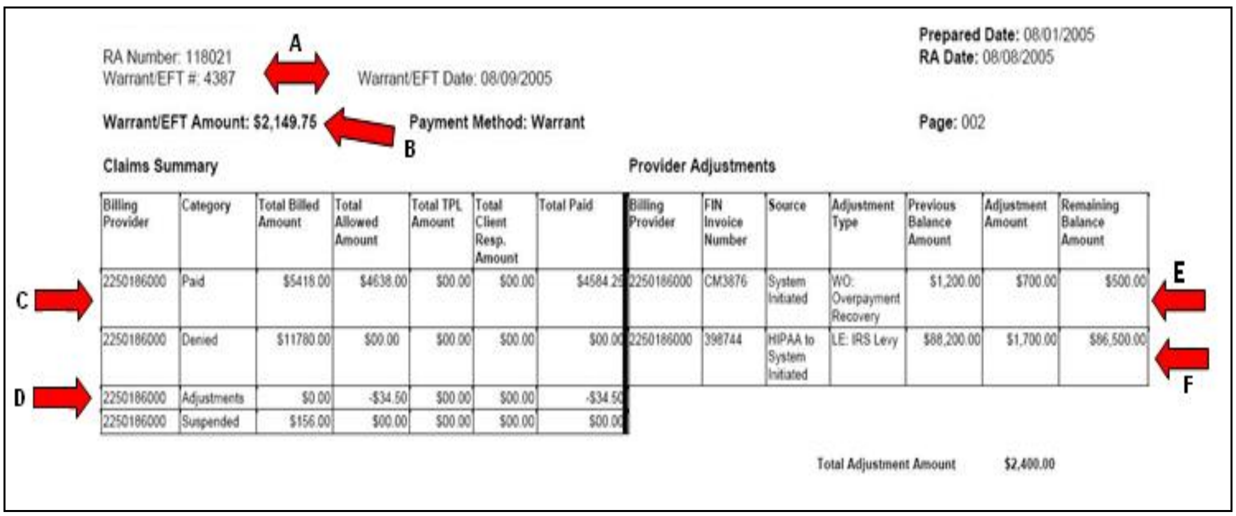
3. Review Summary

Why

Providers can find out the total amount of their Electronic Funds Transfer (EFT) or warrant (check) and how the Agency determined that amount.

How

The summary page lists all claim payments by sections and all other payment and adjustment amounts.



RA Number: 118021
Warrant/EFT #: 4387
Warrant/EFT Date: 08/09/2005
Warrant/EFT Amount: $2,149.75
Payment Method: Warrant
Prepared Date: 08/01/2005
RA Date: 08/08/2005
Page: 002

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Client Resp. Amount	Total Paid
2250186000	Paid	$5418.00	$4638.00	$00.00	$00.00	$4584.25
2250186000	Denied	$11780.00	$00.00	$00.00	$00.00	$00.00
2250186000	Adjustments	$0.00	-$34.50	$00.00	$00.00	-$34.50
2250186000	Suspended	$156.00	$00.00	$00.00	$00.00	$00.00

Provider Adjustments

Billing Provider	FIN Invoice Number	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
2250186000	CM3876	System Initiated	WO: Overpayment Recovery	$1,200.00	$700.00	$500.00
2250186000	398744	HIPAA to System Initiated	LE: IRS Levy	$88,200.00	$1,700.00	$86,500.00

Total Adjustment Amount $2,400.00

Note: This example of the RA is just an approximation of a providers actual RA.

- **A.** Check number and date of payment.
- **B.** Total payment received on the check (warrant) or EFT.
- **C.** Total of the paid claims on this RA.
- **D.** Deduction due to a claim adjustment from the total paid amount.
- **E.** Deduction due to an audit overpayment ($700).
- **F.** Deduction due to an IRS Lien ($1700).

Pitfalls

- **Failing to review any payment adjustments. This could be mistaken as a under payment or an over payment by the Agency.**

Key Step
4

4. Review Paid Claims

Why

The Remittance Advice shows all claims paid during the previous week.

How

- **Review the Paid Claims section(s)**
  - There may be more than one "Paid Claims" section depending upon what services were provided and have been paid. For example, if there were billings for children's Early and Periodic Screening, Diagnosis and Treatment exam (EPSDT) there would be a "Paid Claims – EPSDT Claims" section that would be separate from the "Paid Claims – Professional Claim" section.
  - Be aware of the possibility of multiple paid claim sections to ensure that account payments for all paid claims listed on the RA get posted.

Professional (Physician) Paid Services

RA Number: 118021 | Warrant/EFT #: | Warrant/EFT Date: 11/03/2011 | Prepared Date: 11/04/2011 | RA Date: 11/04/2011
Category: Paid | Billing Provider: 2250186000 | Page 25

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
SMITH, OLIVIA 122224433WA 123477	30113010002255000 Professional Claim	1		10/18/2011- 10/18/2011	99213 25	1.0000	$148.00	$0.00	$0.00	$0.00	$0.00	$0.00		167 = $148.00
	Professional Claim	2		10/18/2011- 10/18/2011	90633 SL	1.0000	$10.00	$5.96	$0.00	$0.00	$0.00	$5.96		45 = $4.04
			Document Total:	10/18/2011-10/18/2011		2.0000	$158.00	$5.96	$0.00	$0.00	$0.00	$5.96		
SMITH, OLIVIA 122224433WA 123477	30113010003344000 Professional Claim	1		10/19/2011- 10/19/2011	99203	1.0000	$220.00	$90.92	$0.00	$0.00	$0.00	$90.92		45 = $129.08
			Document Total:	10/19/2011-10/19/2011		1.0000	$220.00	$90.92	$0.00	$0.00	$0.00	$90.92		
SMITH, OLIVIA 122224433WA 123477	30113010006622000 Professional Claim	1		10/19/2011- 10/19/2011	85025	1.0000	$28.00	$8.64	$0.00	$0.00	$0.00	$8.64		45 = $19.36
	Professional Claim	2		10/19/2011- 10/19/2011	80047 QW	1.0000	$41.00	$7.10	$0.00	$0.00	$0.00	$7.10		45 = $33.90
			Document Total:	10/19/2011-10/19/2011		2.0000	$69.00	$15.74	$0.00	$0.00	$0.00	$15.74		

Note: This example of the RA is just an approximation of a providers actual RA.

EPSDT Paid Children Health Services.

RA Number: 118021 Category: Paid	Warrant/EFT #: Billing Provider: 2250186000			Warrant/EFT Date: 11/03/2011					Prepared Date: 11/04/2011			RA Date: 11/04/2011		Page 13
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
SMITH, OLIVIA 122224433WA 123456	30113010001155000 EPSDT Claim	1		10/19/2011- 10/19/2011	99392 25	1.0000	$191.00	$80.44	$0.00	$0.00	$0.00	$80.44		45 = $110.56
	EPSDT Claim	2		10/19/2011- 10/19/2011	90698 SL	1.0000	$10.00	$5.96	$0.00	$0.00	$0.00	$5.96		45 = $4.04
	EPSDT Claim	3		10/19/2011- 10/19/2011	90716 SL	1.0000	$10.00	$5.96	$0.00	$0.00	$0.00	$5.96		45 = $4.04
	EPSDT Claim	4		10/19/2011- 10/19/2011	90707 SL	1.0000	$10.00	$5.96	$0.00	$0.00	$0.00	$5.96		45 = $4.04
		Document Total:		10/19/2011-10/19/2011		4.0000	$221.00	$98.32	$0.00	$0.00	$0.00	$98.32		
SMITH, OLIVIA 122224433WA 123477	30113010002255000 EPSDT Claim	1		10/25/2011- 10/25/2011	99392 25	1.0000	$191.00	$80.44	$0.00	$0.00	$0.00	$80.44		45 = $110.56
	EPSDT Claim	2		10/25/2011- 10/25/2011	90633 SL	1.0000	$10.00	$5.96	$0.00	$0.00	$0.00	$5.96		45 = $4.04
	EPSDT Claim	3		10/25/2011- 10/25/2011	90655 SL	1.0000	$10.00	$5.96	$0.00	$0.00	$0.00	$5.96		45 = $4.04
		Document Total:		10/25/2011-10/25/2011		3.0000	$211.00	$92.36	$0.00	$0.00	$0.00	$92.36		

Note: This example of the RA is just an approximation of a providers actual RA

Note: Some paid claims may also contain denied service lines. Those denied service lines will still be posted in the paid claims sections within the specific claim that was paid.

Pitfalls

- **Missing a paid claim section. This may result in an unecessary call to the Medical Assistance Customer Service Center (MACSC), or a claim re-bill that causes extra work for both provider and the Agency.**

Key Step

5

5. Review and Research Denied Claims

Why

The Remittance Advice shows all claims denied during the previous week.

How

- Locate the Denied Claims Section on the RA

RA Number: 118421 Warrant/EFT #: Warrant/EFT Date: 11/10/2011 Prepared Date: 11/11/2011 RA Date: 11/11/2011

Category: Denied Billing Provider: 2250186000 Page 169

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
SMITH, C 100117766WA 1227754	301133300088801000 Professional Claim	1	1811989759	03/14/2011- 03/14/2011	99213	1.0000	$148.00	$0.00	$0.00	$0.00	$0.00	$0.00		4 = $148.00
			Document Total:	03/14/2011-03/14/2011		1.0000	$148.00	$0.00	$0.00	$0.00	$0.00	$0.00		
SMITH, C 100117766WA 1227754	301130600000110000 Professional Claim	1	1811989759	03/21/2011- 03/21/2011	99213	1.0000	$148.00	$0.00	$0.00	$0.00	$0.00	$0.00	MA04	4 = $148.00
			Document Total:	03/21/2011-03/21/2011		1.0000	$148.00	$0.00	$0.00	$0.00	$0.00	$0.00		
BROWN, A 1022553388WA 1227754	301124500117730000 Professional Claim	1		11/02/2011- 11/02/2011	99213	1.0000	$148.00	$0.00	$0.00	$0.00	$0.00	$0.00		24 = $148.00
			Document Total:	11/02/2011-11/02/2011		1.0000	$148.00	$0.00	$0.00	$0.00	$0.00	$0.00		24
			The Client listed above enrolled with:	MOLINA HEALTHCARE OF WASHINGTON INC										

Note: This example of the RA is just an approximation of a providers actual RA

- Look for the HIPAA Adjustment Reason and Remark Code to determine why the claims denied. Every denied claim will have a Claim Adjustment Reason Code. Some will also have a Remittance Advice Remark Code for further information. These HIPAA codes are available at: http://www.wpc-edi.com/products/codelists/alertservice.

    - If a provider is still unable to understand the denial, a customer service representative can assist at the Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022.

- After reviewing the HIPAA Adjustment Reason and Remark Codes, determine the denial reason and if the claim can be corrected to be re-billed or resubmitted for reprocessing.
  Re-bill or resubmit when:
    - The entire claim is denied.
    - An individual line on a professional/dental service multiple-line claim is denied. This line can usually be re-billed as a new claim.

- The paid professional/dental claim can be adjusted to correct an error on the denied line of a multiple line claim.

- Providers have 2 years to get this claim re-billed or resubmitted, referencing the original Transaction Control Number (TCN).

- Providers have 6 months from the Medicare process date to re-bill or resubmit a crossover claim.

See Key Step 6 of the "Submit Fee For Service Claims to Medical Assistance" section for more information on adjust/resubmit/void claims.

Note: For claim denials related to private insurance or for clarification billing Medicaid secondary to private insurance, please contact the Coordination of Benefits office at 1-800-562-3022 ext. 16134.

Note: There may be more than one "Denied Claims" section depending upon what services were provided and that have been denied. For example, if the billing was for children's EPSDT screening exam there would be a "Denied Claims – EPSDT Claim" section that would be separate from the "Denied Claims – Professional Claim" section. Be aware of that possibility to ensure that all denied claims are accounted for on the RA.

Pitfalls

- **Missing a denied claim section on the RA. Providers may:**
  - **Overlook a claim or line that needs to be re-billed or resubmitted and delay payment.**
  - **Overlook re-billing or resubmitting a claim or line until it is past the timely billing period.**
  - **Overlook re-billing or resubmitting a claim until it is past the primary payer's timely billing period.**

Key Step

6

6. Review Adjusted Claims

Why

This section of the RA lists claims that have been adjusted or modified from the original billing. Providers may have sent in an adjustment request to correct a paid claim or the Agency has done an adjustment for various reasons. Adjusted claims may affect the amount of the payment for services. Medical Assistance does not process “corrected claims” as such but uses the adjustment process to a paid claim to modify or correct an original claim error.

How

- Page through the RA until the section category labeled “adjustments” is found.

RA Number: 1227638 | Warrant/EFT #: | Warrant/EFT Date: 11/10/2011 | Prepared Date: 11/11/2011 | RA Date: 11/11/2011

Category: Adjustments | Billing Provider: 2250186000 | Page 194

~~Client Name /~~ Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
SMITH, C 100117766WA 1227754 301133300088801000	401130010009994000 Professional Claim	1		10/11/2011- 10/11/2011	99212 2425	1.0000	-$87.00	-$22.93	$0.00	$0.00	$0.00	-$22.93		119 = -$64.07
	401130010009994000 Professional Claim	2		10/11/2011- 10/11/2011	10160 76	1.0000	-$261.00	-$74.28	$0.00	$0.00	$0.00	-$74.28		119 = -$186.72
	401130010009994000 Professional Claim	3		10/10/2011- 10/10/2011	99213 25	1.0000	-$148.00	-$37.84	$0.00	$0.00	$0.00	-$37.84		119 = -$110.16
	401130010009994000 Professional Claim	4		10/10/2011- 10/10/2011	10160	1.0000	-$261.00	-$74.28	$0.00	$0.00	$0.00	-$74.28		119 = -$186.72
		Document Total:		10/10/2011-10/11/2011		4.0000	-$757.00	-$209.33	$0.00	$0.00	$0.00	-$209.33		Credit
SMITH, C 100117766WA 1227754 301133300088801000	301130600000110000 Professional Claim	1		10/11/2011- 10/11/2011	99212 2425	1.0000	$87.00	$22.93	$0.00	$0.00	$0.00	$22.93		45 = $64.07
	301130600000110000 Professional Claim	2		10/11/2011- 10/11/2011	10160 76	1.0000	$261.00	$74.28	$0.00	$0.00	$0.00	$74.28		45 = $186.72
	301130600000110000 Professional Claim	3		10/10/2011- 10/10/2011	10160	1.0000	$261.00	$74.28	$0.00	$0.00	$0.00	$74.28		45 = $186.72
		Document Total:		10/10/2011-10/11/2011		3.0000	$609.00	$171.49	$0.00	$0.00	$0.00	$171.49		Debit

Note: This example of the RA is just an approximation of a providers actual RA.

- Adjustments to modify or correct claim billing errors utilize these basic accounting principles and will have two transactions displayed on the RA.
  - The **Credit** transaction is a copy of the original claim with dollar amounts listed as a negative.
  - The **Debit** transaction is a repayment that displays the modification or corrections made to the original claim and the associated repayment dollar amounts.
  - ProviderOne will then subtract the original payment amount from the adjusted claim payment amount and include this difference in the current payment amount.

Note: Remember the adjustment to the original claim may actually reduce the adjusted claim payment resulting in a subtraction in the current payment amount.

Note: If providers "owe" the Agency more money from adjustments to claims than they earned from other paid claims on the current RA, they may be in a "credit balance" situation. The Agency will wait until providers have been paid enough through subsequent billings to satisfy the "credit balance" situation before making an actual payment. An RA will be made available weekly in any case.

Pitfalls

- **Not reviewing the adjustment section. There may be paid and denied claims in this section.**

Key Step

7

7. Review In-Process Claims

Why

This section of the RA displays claims that are currently in process. These claims are in the payment system but usually pending review by a claim processing staff and will show up on a future RA as a paid or denied claim.

How

Review the section under the "In Process" claims category.

RA Number: 2227638 | Warrant/EFT #: | Warrant/EFT Date: 10/27/2011 | Prepared Date: 10/28/2011 | RA Date: 10/28/2011

Category: In Process | Billing Provider: 2280186000 | Page 39

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
SMITH, C 100117766WA 1227754	201133300088010000	1		07/01/2011-07/01/2011	D0140	1.0000	$85.00	$0.00	$0.00	$0.00	$0.00	$0.00		
	201133300088010000	2		07/01/2011-07/01/2011	D1203	1.0000	$48.00	$0.00	$0.00	$0.00	$0.00	$0.00		
	201133300088010000	3		07/01/2011-07/01/2011	D2930	1.0000	$290.00	$0.00	$0.00	$0.00	$0.00	$0.00		
	201133300088010000	4		07/01/2011-07/01/2011	D2930	1.0000	$290.00	$0.00	$0.00	$0.00	$0.00	$0.00		
	201133300088010000	5		07/01/2011-07/01/2011	D2930	1.0000	$290.00	$0.00	$0.00	$0.00	$0.00	$0.00		
	201133300088010000	6		07/01/2011-07/01/2011	D2930	1.0000	$290.00	$0.00	$0.00	$0.00	$0.00	$0.00		
	201133300088010000	7		07/01/2011-07/01/2011	D3220	1.0000	$180.00	$0.00	$0.00	$0.00	$0.00	$0.00		
		Document Total:		07/01/2011-07/01/2011		7.0000	$1473.00	$0.00	$0.00	$0.00	$0.00	$0.00		

Note: This example of the RA is just an approximation of a providers actual RA.

Pitfalls

- **Rebilling claims because you do not see them in the other sections of the RA. Make sure to review the claims in process section.**

Key Step

8

8. Review the EOB Codes

Why

There could be many reasons a claim could be denied or additional information could be added to a processed claim. Providers can find these HIPAA Adjustment Reason Codes and Remark Codes on the last page of their Remittance Advice.

How

Download the PDF file of the Remittance Advice, locate the claim denial code and then scroll down to the last page of the RA to find the code and code definition.

Adjustment Reason Codes / NCPDP Rejection Codes
119 : Benefit maximum for this time period or occurrence has been reached.
125 : Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
16 : Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
204 : This service/equipment/drug is not covered under the patient's current benefit plan
22 : This care may be covered by another payer per coordination of benefits.
24 : Charges are covered under a capitation agreement/managed care plan.
26 : Expenses incurred prior to coverage.
4 : The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
96 : Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
A1 : Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Remark Codes
M47 : Missing/incomplete/invalid internal or document control number.
MA04 : Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
N152 : Missing/incomplete/invalid replacement claim information.
N329 : Missing/incomplete/invalid patient birth date.
N345 : Date range not valid with units submitted.
N362 : The number of Days or Units of Service exceeds our acceptable maximum.
N428 : Not covered when performed in this place of service.

The complete list of the Federal Adjustment Reason Codes and Remark Codes (as well as the Taxonomy Codes) codes can be located on web page http://www.wpc-edi.com/reference/.

Pitfalls

- **Not downloading the RA to find the denial codes.**
- **Not reviewing the Adjustment Reason Code and the Remark Code if both are on the denied claim.**